which involves a student nurse anesthetist or the physician directs one case involving a student nurse anesthetist and the other involving a CRNA, AA, intern, or resident.

(3) Payment for medical direction is based on a specific percentage of the payment allowance recognized for the anesthesia service personally performed by a physician alone. The following percentages apply for the years specified:

(i) CY 1994—60 percent of the payment allowance for personally performed procedures.

(ii) CY 1995—57.5 percent of the payment allowance for personally performed services.

(iii) CY 1996—55 percent of the payment allowance for personally performed services.

(iv) CY 1997—52.5 percent of the payment allowance for personally performed services.

(v) CY 1998 and thereafter—50 percent of the payment allowance for personally performed services.

(e) *Physicians involved with two concurrent cases with residents.* The physician can bill base units and time units based on the amount of time the physician is actually present with the resident during each of two concurrent cases furnished on or after January 1, 2004.

(1) To bill the base units, the physician must be present with the resident during the pre- and post-anesthesia care included in the base units.

(2) If the physician is not present with the resident during pre- and post-anesthesia care, then the physician may bill the case as a medically directed case in accordance with paragraph (d) of this section.

(f) *Physician medically supervises anesthesia services.* If the physician medically supervises more than four concurrent anesthesia services, CMS bases the fee schedule amount on an anesthesia-specific CF and three base units. This represents payment for the physician's involvement in the pre-surgical anesthesia services.

(g) *Payment for medical or surgical services furnished by a physician while furnishing anesthesia services.* (1) CMS allows separate payment under the fee schedule for certain reasonable and medically necessary medical or surgical services furnished by a physician while furnishing anesthesia services to the patient. CMS makes payment for these services in accordance with the general physician fee schedule rules in §414.20. These services are described in program operating instructions.

(2) CMS makes no separate payment for other medical or surgical services, such as the pre-anesthetic examination of the patient, pre- or post-operative visits, or usual monitoring functions, that are ordinarily included in the anesthesia service.

(h) *Physician involved in multiple anesthesia services.* If the physician is involved in multiple anesthesia services for the same patient during the same operative session, the carrier makes payment according to the base unit associated with the anesthesia service having the highest base unit value and anesthesia time that encompasses the multiple services. The carrier makes payment for add-on anesthesia codes according to program operating instructions.

[56 FR 59624, Nov. 25, 1991, as amended at 57 FR 42492, Sept. 15, 1992; 58 FR 63687, Dec. 2, 1993; 60 FR 63177, Dec. 8, 1995; 64 FR 59441, Nov. 2, 1999; 67 FR 80041, Dec. 31, 2002; 68 FR 63261, Nov. 7, 2003]

### §414.48 Limits on actual charges of nonparticipating suppliers.

(a) *General rule.* A supplier, as defined in §400.202 of this chapter, who is nonparticipating and does not accept assignment may charge a beneficiary an amount up to the limiting charge described in paragraph (b) of this section.

(b) *Specific limits.* For items or services paid under the physician fee schedule, the limiting charge is 115 percent of the fee schedule amount for nonparticipating suppliers. For items or services CMS excludes from payment under the physician fee schedule (in accordance with section 1848 (j)(3) of the Act), the limiting charge is 115 percent of 95 percent of the payment basis applicable to participating suppliers as calculated in §414.20(b).

[58 FR 63687, Dec. 2, 1993, as amended at 62 FR 59102, Oct. 31, 1997]